Governor's Listening Session

August 28, 2002

Thank you for the opportunity to speak today. My name is Fred Moore. I'm CEO of Wausau Benefits, Inc.

Health care costs are of great concern to us as an employer and as a business.

Wausau Benefits is a third-party administrator of employee benefits for employers who self fund their health plans. We handle about $3.0 billion of our customers' health care dollars each year.

We work hard to help our clients keep their costs reasonable.

And it **is** hard work!

I know you have heard good anecdotal evidence from several employers at previous listening sessions.
I'd like to give you some statistics from the Washington Business Group on Health.

- National health spending will double by 2011 from $1.5 TRILLION to $2.8 TRILLION!
- Employer health care costs have risen 50 percent over the past five years.
- They rose 12 percent in 2001 and 14 percent in 2002.
- We expect another 14 percent increase in 2003.

It is clear that corporate America cannot make or sell enough goods and services in this economy to keep absorbing these cost increases. Neither can we afford government when personnel and program costs reflect these expense levels.

The problem of rising health care costs will take, according to some health policy experts, a 'fundamental cultural shift in the American approach to medicine.'

This is a big order.

Our cultural attitude toward health care is best summed up by this statement: "Americans want the best health care that *someone else* will pay for!" That probably won't change in your lifetime or mine.

Cultural issues aside, there are factors driving health care costs up, some we cannot affect, others we can.

The cost drivers are a combination of demographics, pharmaceutical changes, dramatic improvements in medical technology and the cost pressures of certain labor shortages and government cost shifting.

Unfortunately, as the nation goes, so goes Wisconsin, with some unhealthy differences.

Like the nation, our population is getting to the age where things tend to plug up, break down and wear out.

And we do not suffer such things gladly or passively. We stubbornly refuse to die of things that would have killed us a few years ago. All it takes is $150,000 here and there. We insist on getting things fixed in part because medical procedures are safer and more convenient than ever. Everybody knows somebody who would have put up with a bum knee or a sinus problem a few years ago, but has now had the problem corrected. The good news is that there are more and more effective therapies available to help us feel and function well. The bad news is it all costs money.

Our aging population is living with more and more chronic disease. Statistics show that for every 100 people

- 27 have cardiovascular disease.
- 24 have high blood pressure.
- More than 50 have high cholesterol.
- 5 have diabetes.
- And five have diabetes but haven't been diagnosed.

Folks can live with these conditions but there is a price. In fact, 50 percent of health care costs are directly related to a list of 7 or 8 chronic diseases.

In 30 years, we can expect the nation's annual health care costs for chronic disease to soar to $800 billion.

Add to that: hospital costs are going up nearly everywhere. The reasons are many. They include the understandable costs of better therapies. They include the impact of a shortage of nurses and other skilled workers. And, they include the shifting of costs from Federal programs which underpay providers and the uncompensated care, $216 billion in 2000, that hospitals are required to give to people who are uninsured or not covered by government programs.

Full-time nursing salaries rose by as much as 10 percent across the country from 2000 to 2001. Hospitals do and will continue to spend millions using traveling nurses and agencies to fill the slots left vacant by the shortage of staff nurses.

Pharmacist salaries rose by as much as 13 percent.

Compliance with HIPAA privacy, security and transaction regulations is expected to cost hospitals alone between $4 billion and $22 billion. There are similar costs in other provider and payer organizations.

Prescription drugs have also had a major impact on costs. The cost of drug ingredients, the frequency of prescriptions dispensed, the impact of direct-to-consumer advertising have caused prescription drug costs to shoot from $34 billion in 1990 to $128 billion in 2000. And we expect that number to rise to $248 billion in 2008!

The cost of a pint of blood increased an average of 31 percent in 2001. In some states blood costs increased by 100 percent. New Federal safety rules will soon further adversely impact the supply and cost of donated blood.

So what about our state? How do we fare? Not well.

In Wisconsin, much of our population is covered by collectively bargained health plans that are 10 to 20 years old. These were bargained in good faith when health care costs were lower and fewer therapies were available. Unfortunately, many of these plans pay, in economic terms subsidize, virtually all of the cost of covered medical benefits. People just don't spend other people's money as wisely as they do their own. Until recently, we didn't understand the impact of the individual on health status nor did we fully comprehend healthcare buying patterns.

We **are** the Dairy State…we love our cows in all forms…liquid, congealed or grilled. Add in our fondness for beer, brats and brandy and it's no surprise most of us have a widening waistline! Maybe it's the brandy, but we also smoke too much. 24.1% of our population smokes—which is above the US average of 23.2%. Those facts have profound individual impacts on health status and health care costs.

We are a state where medicine is good and very available. While it's an exaggeration, some say that you can tell that a Wisconsin town has over 2,500 people because it usually has a hospital! And medical malls, some call them clinics, are everywhere and promoted in every medium. We all have seen examples where the presence of more hospitals and clinics lead to higher utilization and higher costs.

So what can we do? Wring our hands? Go to war with Labor?

Well, there **is** going to be some discussion with unions when so many organizations are facing the difficult choice of paying higher wages or higher health care expenses. Member responsibility for some health care expenditure is a good idea.

The better answer, however, is to find new ways to tackle these problems and develop the resolve to work for short- and long-term solutions.

They are attainable.

To start, we must address the supply of trained health-care workers. Currently our local Community Health Care organization has a nursing turnover of about 100 positions per year. Our local NorthCentral Technical College only trains about 30 per year. We have to do more to decrease that gap and this community is doing so.

We have to do more to create true competition among medical delivery systems in a free economy.

Competition must be based on cost and quality...not price.

Cost and price are not the same thing.

Cost is the amount of resources consumed between the time a person begins care and finishes treatment, sometimes, not always, the time period between becoming ill and getting well. Price is the dollar level of charge made by a provider for a particular service.

You can find real differences between medical systems when the true cost of an episode of care is analyzed.

Methodologies exist to measure these costs. And, using this information, in markets where cost competition exists, employers can create benefit plans to help their employees choose high quality, lower cost care more efficiently and effectively.

In these markets, hospitals and clinics compete on a fair and measured basis—on cost, not just on price discounts.

Is this relevant in Wisconsin cities where there is only one integrated clinical organization? Not particularly.

Is this relevant in Wisconsin's larger cities, like Milwaukee? You bet.

Is this relevant in cities like Wausau where more choices are becoming available? Yes!

Wausau Benefits has experience with just such a model. It is our relationship with Patient Choice and the Buyers Health Care Action Group in Minneapolis.

The Group, folks call them BHCAG, and Patient Choice developed a unique and proven health care financing model for self-funded employers.

It is dramatically different from HMOs or PPOs.

The Patient Choice model provides a consumer-driven health care services program where patients choose their care systems; health care professionals make health care decisions; employers define and manage their costs; and consumers make choices based on price and quality of care.

Choice increases employee satisfaction.

Choice makes essential cost-sharing more palatable.

Choice encourages competition on value, quality, innovation and consumer preferences.

We must address the issue of quality. It is clear that getting the right care sooner rather than later will result in faster recoveries and less costs.

For example, surgical patients with a rotator-cuff tear lost 5.3 weeks of work compared with 12.2 weeks for patients who didn't have surgery. Patients with a meniscus tear of the knee who had arthroscopic repair lost 5.2 weeks of work compared with 9.7 weeks for nonsurgical patients. Clearly the old approach of 1-800-DENY-CARE was wrong.

We must do what we can to help health care providers deliver quality care. That doesn't mean throwing more money at the situation. It means finding the right balance.

A MEDSTAT Group study showed that as care rises in cost it begins to fall in terms of quality. There is a point at which spending more does not necessarily improve quality. We must not stray beyond that point.

Understanding physicians as essential partners is significant. Patients in America trust their doctors. We will get nowhere if we try to interfere with that trust.

Instead we need to help their doctors understand everything that is being paid, not just what is covered. We need to give their doctors data on performance measures and alert them to all the treatment a plan member is or is not getting.

We need to give patients the information and empowerment to manage their conditions.

This doesn't mean stepping between them and their doctors. It means employing a patient-centric approach to disease management that gives responsibility and information to the patient and physician.

It means changing patients' behavior from knowing they *should* change their lifestyle to *wanting* to change in order to improve their health. Informed patients have better outcomes.

If we don't do those things, Wisconsin's share of the coming nation's bill for chronic disease will be about $16 billion per year.

There are solutions.

Disease management makes sense.

Case management of catastrophic illness and injury makes sense.

Work-based wellness programs make sense.

Competition based on cost and quality makes sense.

Wisconsin has health-care cost problems, but we have a strong and proud history of facing our problems

And overcoming them.

We have one of the lowest unemployment rates and cost of living indices in the nation.

Our educational system is one of the best in the country.

Our government has been progressive and innovative. Let's keep it that way.

I thank you for the opportunity to speak with you today. This debate allows us to air our concerns but more importantly our solutions.

And fresh air is good for us all!